

26-33a-101. Short title.

This chapter is known as the "Utah Health Data Authority Act."

Enacted by Chapter 305, 1990 General Session

26-33a-102. Definitions.

As used in this chapter:

- (1) "Committee" means the Health Data Committee created by Section 26-1-7.
- (2) "Control number" means a number assigned by the committee to an individual's health data as an identifier so that the health data can be disclosed or used in research and statistical analysis without readily identifying the individual.
- (3) "Data supplier" means a health care facility, health care provider, self-funded employer, third-party payor, health maintenance organization, or government department which could reasonably be expected to provide health data under this chapter.
- (4) "Disclosure" or "disclose" means the communication of health care data to any individual or organization outside the committee, its staff, and contracting agencies.
- (5) "Executive director" means the director of the department.
- (6) "Health care facility" means a facility that is licensed by the department under Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act. The committee may by rule add, delete, or modify the list of facilities that come within this definition for purposes of this chapter.
- (7) "Health care provider" means any person, partnership, association, corporation, or other facility or institution that renders or causes to be rendered health care or professional services as a physician, registered nurse, licensed practical nurse, nurse-midwife, dentist, dental hygienist, optometrist, clinical laboratory technologist, pharmacist, physical therapist, podiatric physician, psychologist, chiropractic physician, naturopathic physician, osteopathic physician, osteopathic physician and surgeon, audiologist, speech pathologist, certified social worker, social service worker, social service aide, marriage and family counselor, or practitioner of obstetrics, and others rendering similar care and services relating to or arising out of the health needs of persons or groups of persons, and officers, employees, or agents of any of the above acting in the course and scope of their employment.
- (8) "Health data" means information relating to the health status of individuals, health services delivered, the availability of health manpower and facilities, and the use and costs of resources and services to the consumer, except vital records as defined in Section 26-2-2 shall be excluded.
- (9) "Health maintenance organization" has the meaning set forth in Section 31A-8-101.
- (10) "Identifiable health data" means any item, collection, or grouping of health data that makes the individual supplying or described in the health data identifiable.
- (11) "Individual" means a natural person.
- (12) "Organization" means any corporation, association, partnership, agency, department, unit, or other legally constituted institution or entity, or part thereof.
- (13) "Research and statistical analysis" means activities using health data analysis including:

- (a) describing the group characteristics of individuals or organizations;
- (b) analyzing the noncompliance among the various characteristics of individuals or organizations;
- (c) conducting statistical procedures or studies to improve the quality of health data;
- (d) designing sample surveys and selecting samples of individuals or organizations; and
- (e) preparing and publishing reports describing these matters.

(14) "Self-funded employer" means an employer who provides for the payment of health care services for employees directly from the employer's funds, thereby assuming the financial risks rather than passing them on to an outside insurer through premium payments.

(15) "Plan" means the plan developed and adopted by the Health Data Committee under Section 26-33a-104.

(16) "Third party payor" means:

- (a) an insurer offering a health benefit plan, as defined by Section 31A-1-301, to at least 2,500 enrollees in the state;
- (b) a nonprofit health service insurance corporation licensed under Title 31A, Chapter 7, Nonprofit Health Service Insurance Corporations;
- (c) a program funded or administered by Utah for the provision of health care services, including the Medicaid and medical assistance programs described in Chapter 18, Medical Assistance Act; and
- (d) a corporation, organization, association, entity, or person:
 - (i) which administers or offers a health benefit plan to at least 2,500 enrollees in the state; and
 - (ii) which is required by administrative rule adopted by the department in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to supply health data to the committee.

Amended by Chapter 400, 2011 General Session

26-33a-103. Committee membership -- Terms -- Chair -- Compensation.

(1) The Health Data Committee created by Section 26-1-7 shall be composed of 15 members.

(2) (a) One member shall be:

- (i) the commissioner of the Utah Insurance Department; or
- (ii) the commissioner's designee who shall have knowledge regarding the health care system and characteristics and use of health data.

(b) Fourteen members shall be appointed by the governor with the consent of the Senate in accordance with Subsection (3). No more than seven members of the committee appointed by the governor may be members of the same political party.

(3) The members of the committee appointed under Subsection (2)(b) shall:

- (a) be knowledgeable regarding the health care system and the characteristics and use of health data;
- (b) be selected so that the committee at all times includes individuals who provide care;

(c) include one person employed by or otherwise associated with a general acute hospital as defined by Section 26-21-2, who is knowledgeable about the collection, analysis, and use of health care data;

(d) include two physicians, as defined in Section 58-67-102:

(i) who are licensed to practice in this state;

(ii) who actively practice medicine in this state;

(iii) who are trained in or have experience with the collection, analysis, and use of health care data; and

(iv) one of whom is selected by the Utah Medical Association;

(e) include three persons:

(i) who are:

(A) employed by or otherwise associated with a business that supplies health care insurance to its employees; and

(B) knowledgeable about the collection and use of health care data; and

(ii) at least one of whom represents an employer employing 50 or fewer employees;

(f) include three persons representing health insurers:

(i) at least one of whom is employed by or associated with a third-party payor that is not licensed under Title 31A, Chapter 8, Health Maintenance Organizations and Limited Health Plans;

(ii) at least one of whom is employed by or associated with a third party payer that is licensed under Title 31A, Chapter 8, Health Maintenance Organizations and Limited Health Plans; and

(iii) who are trained in, or experienced with the collection, analysis, and use of health care data;

(g) include two consumer representatives:

(i) from organized consumer or employee associations; and

(ii) knowledgeable about the collection and use of health care data;

(h) include one person:

(i) representative of a neutral, non-biased entity that can demonstrate that it has the broad support of health care payers and health care providers; and

(ii) who is knowledgeable about the collection, analysis, and use of health care data; and

(i) include two persons representing public health who are trained in, or experienced with the collection, use, and analysis of health care data.

(4) (a) Except as required by Subsection (4)(b), as terms of current committee members expire, the governor shall appoint each new member or reappointed member to a four-year term.

(b) Notwithstanding the requirements of Subsection (4)(a), the governor shall, at the time of appointment or reappointment, adjust the length of terms to ensure that the terms of committee members are staggered so that approximately half of the committee is appointed every two years.

(c) Members may serve after their terms expire until replaced.

(5) When a vacancy occurs in the membership for any reason, the replacement shall be appointed for the unexpired term.

(6) Committee members shall annually elect a chair of the committee from

among their membership. The chair shall report to the executive director.

(7) The committee shall meet at least once during each calendar quarter. Meeting dates shall be set by the chair upon 10 working days notice to the other members, or upon written request by at least four committee members with at least 10 working days notice to other committee members.

(8) Eight committee members constitute a quorum for the transaction of business. Action may not be taken except upon the affirmative vote of a majority of a quorum of the committee.

(9) A member may not receive compensation or benefits for the member's service, but may receive per diem and travel expenses in accordance with:

(a) Section 63A-3-106;

(b) Section 63A-3-107; and

(c) rules made by the Division of Finance pursuant to Sections 63A-3-106 and 63A-3-107.

(10) All meetings of the committee shall be open to the public, except that the committee may hold a closed meeting if the requirements of Sections 52-4-204, 52-4-205, and 52-4-206 are met.

Amended by Chapter 118, 2014 General Session

26-33a-104. Purpose, powers, and duties of the committee.

(1) The purpose of the committee is to direct a statewide effort to collect, analyze, and distribute health care data to facilitate the promotion and accessibility of quality and cost-effective health care and also to facilitate interaction among those with concern for health care issues.

(2) The committee shall:

(a) develop and adopt by rule, following public hearing and comment, a health data plan that shall among its elements:

(i) identify the key health care issues, questions, and problems amenable to resolution or improvement through better data, more extensive or careful analysis, or improved dissemination of health data;

(ii) document existing health data activities in the state to collect, organize, or make available types of data pertinent to the needs identified in Subsection (2)(a)(i);

(iii) describe and prioritize the actions suitable for the committee to take in response to the needs identified in Subsection (2)(a)(i) in order to obtain or to facilitate the obtaining of needed data, and to encourage improvements in existing data collection, interpretation, and reporting activities, and indicate how those actions relate to the activities identified under Subsection (2)(a)(ii);

(iv) detail the types of data needed for the committee's work, the intended data suppliers, and the form in which such data are to be supplied, noting the consideration given to the potential alternative sources and forms of such data and to the estimated cost to the individual suppliers as well as to the department of acquiring these data in the proposed manner; the plan shall reasonably demonstrate that the committee has attempted to maximize cost-effectiveness in the data acquisition approaches selected;

(v) describe the types and methods of validation to be performed to assure data validity and reliability;

(vi) explain the intended uses of and expected benefits to be derived from the data specified in Subsection (2)(a)(iv), including the contemplated tabulation formats and analysis methods; the benefits described shall demonstrably relate to one or more of the following:

- (A) promoting quality health care;
- (B) managing health care costs; or
- (C) improving access to health care services;

(vii) describe the expected processes for interpretation and analysis of the data flowing to the committee; noting specifically the types of expertise and participation to be sought in those processes; and

(viii) describe the types of reports to be made available by the committee and the intended audiences and uses;

(b) have the authority to collect, validate, analyze, and present health data in accordance with the plan while protecting individual privacy through the use of a control number as the health data identifier;

(c) evaluate existing identification coding methods and, if necessary, require by rule that health data suppliers use a uniform system for identification of patients, health care facilities, and health care providers on health data they submit under this chapter; and

(d) advise, consult, contract, and cooperate with any corporation, association, or other entity for the collection, analysis, processing, or reporting of health data identified by control number only in accordance with the plan.

(3) The committee may adopt rules to carry out the provisions of this chapter in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

(4) Except for data collection, analysis, and validation functions described in this section, nothing in this chapter shall be construed to authorize or permit the committee to perform regulatory functions which are delegated by law to other agencies of the state or federal governments or to perform quality assurance or medical record audit functions that health care facilities, health care providers, or third party payors are required to conduct to comply with federal or state law. The committee may not recommend or determine whether a health care provider, health care facility, third party payor, or self-funded employer is in compliance with federal or state laws including federal or state licensure, insurance, reimbursement, tax, malpractice, or quality assurance statutes or common law.

(5) Nothing in this chapter shall be construed to require a data supplier to supply health data identifying a patient by name or describing detail on a patient beyond that needed to achieve the approved purposes included in the plan.

(6) No request for health data shall be made of health care providers and other data suppliers until a plan for the use of such health data has been adopted.

(7) If a proposed request for health data imposes unreasonable costs on a data supplier, due consideration shall be given by the committee to altering the request. If the request is not altered, the committee shall pay the costs incurred by the data supplier associated with satisfying the request that are demonstrated by the data supplier to be unreasonable.

(8) After a plan is adopted as provided in Section 26-33a-106.1, the committee may require any data supplier to submit fee schedules, maximum allowable costs, area

prevailing costs, terms of contracts, discounts, fixed reimbursement arrangements, capitations, or other specific arrangements for reimbursement to a health care provider.

(9) The committee may not publish any health data collected under Subsection (8) that would disclose specific terms of contracts, discounts, or fixed reimbursement arrangements, or other specific reimbursement arrangements between an individual provider and a specific payer.

(10) Nothing in Subsection (8) shall prevent the committee from requiring the submission of health data on the reimbursements actually made to health care providers from any source of payment, including consumers.

Amended by Chapter 167, 2013 General Session

26-33a-105. Executive secretary -- Appointment -- Powers.

(1) An executive secretary shall be appointed by the executive director, with the approval of the committee, and shall serve under the administrative direction of the executive director.

(2) The executive secretary shall:

- (a) employ full-time employees necessary to carry out this chapter;
- (b) supervise the development of a draft health data plan for the committee's review, modification, and approval; and
- (c) supervise and conduct the staff functions of the committee in order to assist the committee in meeting its responsibilities under this chapter.

Enacted by Chapter 305, 1990 General Session

26-33a-106. Limitations on use of health data.

The committee may not use the health data provided to it by third-party payors, health care providers, or health care facilities to make recommendations with regard to a single health care provider or health care facility, or a group of health care providers or health care facilities.

Amended by Chapter 201, 1996 General Session

26-33a-106.1. Health care cost and reimbursement data.

(1) The committee shall, as funding is available:

- (a) establish a plan for collecting data from data suppliers, as defined in Section 26-33a-102, to determine measurements of cost and reimbursements for risk-adjusted episodes of health care;
- (b) share data regarding insurance claims and an individual's and small employer group's health risk factor and characteristics of insurance arrangements that affect claims and usage with the Insurance Department, only to the extent necessary for:
 - (i) risk adjusting; and
 - (ii) the review and analysis of health insurers' premiums and rate filings; and
- (c) assist the Legislature and the public with awareness of, and the promotion of, transparency in the health care market by reporting on:

- (i) geographic variances in medical care and costs as demonstrated by data available to the committee; and
 - (ii) rate and price increases by health care providers:
 - (A) that exceed the Consumer Price Index - Medical as provided by the United States Bureau of Labor Statistics;
 - (B) as calculated yearly from June to June; and
 - (C) as demonstrated by data available to the committee; and
 - (d) provide on at least a monthly basis, enrollment data collected by the committee to a not-for-profit, broad-based coalition of state health care insurers and health care providers that are involved in the standardized electronic exchange of health data as described in Section 31A-22-614.5, to the extent necessary:
 - (i) for the department or the Medicaid Office of the Inspector General to determine insurance enrollment of an individual for the purpose of determining Medicaid third party liability;
 - (ii) for an insurer that is a data supplier, to determine insurance enrollment of an individual for the purpose of coordination of health care benefits; and
 - (iii) for a health care provider, to determine insurance enrollment for a patient for the purpose of claims submission by the health care provider.
- (2) (a) The Medicaid Office of Inspector General shall annually report to the Legislature's Health and Human Services Interim Committee regarding how the office used the data obtained under Subsection (1)(d)(i) and the results of obtaining the data.
- (b) A data supplier shall not be liable for a breach of or unlawful disclosure of the data obtained by an entity described in Subsection (1)(b).
- (3) The plan adopted under Subsection (1) shall include:
- (a) the type of data that will be collected;
 - (b) how the data will be evaluated;
 - (c) how the data will be used;
 - (d) the extent to which, and how the data will be protected; and
 - (e) who will have access to the data.

Amended by Chapter 118, 2014 General Session

Amended by Chapter 425, 2014 General Session

Amended by Chapter 425, 2014 General Session, (Coordination Clause)

26-33a-106.5. Comparative analyses.

- (1) The committee may publish compilations or reports that compare and identify health care providers or data suppliers from the data it collects under this chapter or from any other source.
- (2) (a) Except as provided in Subsection (7)(c), the committee shall publish compilations or reports from the data it collects under this chapter or from any other source which:
 - (i) contain the information described in Subsection (2)(b); and
 - (ii) compare and identify by name at least a majority of the health care facilities, health care plans, and institutions in the state.
- (b) Except as provided in Subsection (7)(c), the report required by this Subsection (2) shall:

- (i) be published at least annually; and
- (ii) contain comparisons based on at least the following factors:
 - (A) nationally or other generally recognized quality standards;
 - (B) charges; and
 - (C) nationally recognized patient safety standards.

(3) The committee may contract with a private, independent analyst to evaluate the standard comparative reports of the committee that identify, compare, or rank the performance of data suppliers by name. The evaluation shall include a validation of statistical methodologies, limitations, appropriateness of use, and comparisons using standard health services research practice. The analyst shall be experienced in analyzing large databases from multiple data suppliers and in evaluating health care issues of cost, quality, and access. The results of the analyst's evaluation shall be released to the public before the standard comparative analysis upon which it is based may be published by the committee.

(4) The committee shall adopt by rule a timetable for the collection and analysis of data from multiple types of data suppliers.

(5) The comparative analysis required under Subsection (2) shall be available:

- (a) free of charge and easily accessible to the public; and
- (b) on the Health Insurance Exchange either directly or through a link.

(6) (a) The department shall include in the report required by Subsection (2)(b), or include in a separate report, comparative information on commonly recognized or generally agreed upon measures of cost and quality identified in accordance with Subsection (7), for:

- (i) routine and preventive care; and
- (ii) the treatment of diabetes, heart disease, and other illnesses or conditions as determined by the committee.

(b) The comparative information required by Subsection (6)(a) shall be based on data collected under Subsection (2) and clinical data that may be available to the committee, and shall compare:

- (i) beginning December 31, 2014, results for health care facilities or institutions;
- (ii) beginning December 31, 2014, results for health care providers by geographic regions of the state;

(iii) beginning July 1, 2016, a clinic's aggregate results for a physician who practices at a clinic with five or more physicians; and

(iv) beginning July 1, 2016, a geographic region's aggregate results for a physician who practices at a clinic with less than five physicians, unless the physician requests physician-level data to be published on a clinic level.

(c) The department:

(i) may publish information required by this Subsection (6) directly or through one or more nonprofit, community-based health data organizations;

(ii) may use a private, independent analyst under Subsection (3) in preparing the report required by this section; and

(iii) shall identify and report to the Legislature's Health and Human Services Interim Committee by July 1, 2014, and every July 1 thereafter until July 1, 2019, at least three new measures of quality to be added to the report each year.

(d) A report published by the department under this Subsection (6):

- (i) is subject to the requirements of Section 26-33a-107; and
 - (ii) shall, prior to being published by the department, be submitted to a neutral, non-biased entity with a broad base of support from health care payers and health care providers in accordance with Subsection (7) for the purpose of validating the report.
- (7) (a) The Health Data Committee shall, through the department, for purposes of Subsection (6)(a), use the quality measures that are developed and agreed upon by a neutral, non-biased entity with a broad base of support from health care payers and health care providers.
- (b) If the entity described in Subsection (7)(a) does not submit the quality measures, the department may select the appropriate number of quality measures for purposes of the report required by Subsection (6).
- (c) (i) For purposes of the reports published on or after July 1, 2014, the department may not compare individual facilities or clinics as described in Subsections (6)(b)(i) through (iv) if the department determines that the data available to the department can not be appropriately validated, does not represent nationally recognized measures, does not reflect the mix of cases seen at a clinic or facility, or is not sufficient for the purposes of comparing providers.
- (ii) The department shall report to the Legislature's Executive Appropriations Committee prior to making a determination not to publish a report under Subsection (7)(c)(i).

Amended by Chapter 425, 2014 General Session

26-33a-107. Limitations on release of reports.

The committee may not release a compilation or report that compares and identifies health care providers or data suppliers unless it:

- (1) allows the data supplier and the health care provider to verify the accuracy of the information submitted to the committee and submit to the committee any corrections of errors with supporting evidence and comments within a reasonable period of time to be established by rule;
- (2) corrects data found to be in error; and
- (3) allows the data supplier a reasonable amount of time prior to publication to review the committee's interpretation of the data and prepare a response.

Amended by Chapter 201, 1996 General Session

26-33a-108. Disclosure of identifiable health data prohibited.

(1) All information, reports, statements, memoranda, or other data received by the committee are strictly confidential. Any use, release, or publication of the information shall be done in such a way that no person is identifiable except as provided in Sections 26-33a-107 and 26-33a-109.

(2) No member of the committee may be held civilly liable by reason of having released or published reports or compilations of data supplied to the committee, so long as the publication or release is in accordance with the requirements of Subsection (1).

(3) No person, corporation, or entity may be held civilly liable for having provided data to the committee in accordance with this chapter.

Amended by Chapter 201, 1996 General Session

26-33a-109. Exceptions to prohibition on disclosure of identifiable health data.

- (1) The committee may not disclose any identifiable health data unless:
 - (a) the individual has authorized the disclosure; or
 - (b) the disclosure complies with the provisions of:
 - (i) this section;
 - (ii) insurance enrollment and coordination of benefits under Subsection 26-33a-106.1(1)(d); or
 - (iii) risk adjusting under Subsection 26-33a-106.1(1)(b).
- (2) The committee shall consider the following when responding to a request for disclosure of information that may include identifiable health data:
 - (a) whether the request comes from a person after that person has received approval to do the specific research and statistical work from an institutional review board; and
 - (b) whether the requesting entity complies with the provisions of Subsection (3).
- (3) A request for disclosure of information that may include identifiable health data shall:
 - (a) be for a specified period; or
 - (b) be solely for bona fide research and statistical purposes as determined in accordance with administrative rules adopted by the department, which shall require:
 - (i) the requesting entity to demonstrate to the department that the data is required for the research and statistical purposes proposed by the requesting entity; and
 - (ii) the requesting entity to enter into a written agreement satisfactory to the department to protect the data in accordance with this chapter or other applicable law.
- (4) A person accessing identifiable health data pursuant to Subsection (3) may not further disclose the identifiable health data:
 - (a) without prior approval of the department; and
 - (b) unless the identifiable health data is disclosed or identified by control number only.

Amended by Chapter 425, 2014 General Session

26-33a-110. Penalties.

- (1) Any use, release, or publication of health care data contrary to the provisions of Sections 26-33a-108 and 26-33a-109 is a class A misdemeanor.
- (2) Subsection (1) does not relieve the person or organization responsible for that use, release, or publication from civil liability.

Enacted by Chapter 305, 1990 General Session

26-33a-111. Health data not subject to subpoena or compulsory process -- Exception.

Identifiable health data obtained in the course of activities undertaken or supported under this chapter are not subject to subpoena or similar compulsory process in any civil or criminal, judicial, administrative, or legislative proceeding, nor shall any individual or organization with lawful access to identifiable health data under the provisions of this chapter be compelled to testify with regard to such health data, except that data pertaining to a party in litigation may be subject to subpoena or similar compulsory process in an action brought by or on behalf of such individual to enforce any liability arising under this chapter.

Amended by Chapter 297, 2011 General Session

26-33a-115. Consumer-focused health care delivery and payment reform demonstration project.

(1) The Legislature finds that:

(a) current health care delivery and payment systems do not provide system wide incentives for the competitive delivery and pricing of health care services to consumers;

(b) there is a compelling state interest to encourage consumers to seek high quality, low cost care and educate themselves about health care options;

(c) some health care providers and health care payers have developed consumer-focused ideas for health care delivery and payment system reform, but lack the critical number of patient lives and payer involvement to accomplish system-wide consumer-focused reform; and

(d) there is a compelling state interest to encourage as many health care providers and health care payers to join together and coordinate efforts at consumer-focused health care delivery and payment reform that would provide to consumers enrolled in a high-deductible health plan:

(i) greater choice in health care options;

(ii) improved services through competition; and

(iii) more affordable options for care.

(2) (a) The department shall meet with health care providers and health care payers for the purpose of coordinating a demonstration project for consumer-based health care delivery and payment reform.

(b) Participation in the coordination efforts is voluntary, but encouraged.

(3) The department, in order to facilitate the coordination of a demonstration project for consumer-based health care delivery and payment reform, shall convene and consult with pertinent entities including:

(a) the Utah Insurance Department;

(b) the Office of Consumer Health Services;

(c) the Utah Medical Association;

(d) the Utah Hospital Association; and

(e) neutral, non-biased third parties with an established record for broad based, multi-provider and multi-payer quality assurance efforts and data collection.

(4) The department shall supervise the efforts by entities under Subsection (3) regarding:

(a) applying for and obtaining grant funding and other financial assistance that

may be available for demonstrating consumer-based improvements to health care delivery and payment;

(b) obtaining and analyzing information and data related to current health system utilization and costs to consumers; and

(c) consulting with those health care providers and health care payers who elect to participate in the consumer-based health delivery and payment demonstration project.

(5) The executive director shall report to the Health System Reform Task Force by January 1, 2015, regarding the progress toward coordination of consumer-focused health care system payment and delivery reform.

Enacted by Chapter 102, 2013 General Session